

Aaronson, Lauren 2009

Dr. Lauren Aaronson Oral History

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NINR History Project

Telephone Interview with Dr. Lauren Aaronson Conducted on September 4, 2009, by Philip Cantelon

PC: I'm speaking with Lauren, L-A-U-R-E-N, Aaronson, A-A-R-O-N-S-O-N, on September 4th, 2009. I have your permission to record the call?

LA: Yes.

PC: And use the material in the book on nursing?

LA: Yes.

PC: Thank you very much. What I noticed in your brief bio is that you were present at the creation in the initial workshops to establish or push for the NCNR.

LA: Yes. That was some time back.

PC: Tell me a little bit about that.

LA: That's certainly dredging up some old memories. Let's see. I remember that we were a large group of nurse investigators that were brought in to meet and I think they were like all-day workshops. We were separated into different groups to look at different broad areas like health promotion, symptom management, healthcare systems or delivery, and talking about what should be the focus and the emphasis of what we hoped would become the national institute for nursing research on the NIH campus.

PC: Did this grow into the National Nursing Research Agenda?

LA: Yes. It became the priorities that were established. It really is some time back, so I apologize but I'm having a hard time remembering all the differences. As you give me those prompts, I would say yes. Eventually what was to come out of it would be the agenda and therefore then the priority areas for program announcements or just to alert the community nationally of the areas in which we hoped to foster and stimulate more research.

PC: I guess what later became known as CORP and CORP2, the Council on Research Priorities? Drawing a blank there?

LA: Yes. Sorry.

PC: And then later you have the Emerging Research Themes Working Group in 2002.

LA: Yes. That was more recent, and I think those were a series of, a handful at least, of different groups that were brought in for a one-day discussion.

PC: And this is brought in by NINR?

LA: By NINR, yes.

PC: Over the years that you've been working in—your first grant with NCNR/NINR was when?

LA: Let's see. My funding predated them, so my first grant was probably a transfer from the Division of Nursing in HRSA to the NCNR, so whatever year that was in the eighties, '85 maybe.

PC: Eighty-six probably.

LA: Yes, whatever was there. The grant transferred from HRSA to the NIH when that was drafted. So yes, I was one of the early grant recipients.

PC: And a recent one as well, I take it.

LA: Well, of recent years I have been more working as a senior co-investigator for some junior faculty to launch their careers. So other than, let's see. No, because my most recent is not from NINR. I subsequently got a center grant and such from NINR. Let's see. No, that one's NCHD. The most recent NINR-funded grant that I've been involved with was the PI was Karen Wambach, and that one probably ended a year ago maybe, or last December, one of the two.

PC: Over the years, you've had a good chance to work with and watch the nursing institute at NIH, whether it was a center or an institute. In your evaluation, what has been the impact of that on the nursing science and research profession?

LA: NINR? Impact on nursing science? I think it's been huge. Having that institute as a source of funding for nursing research made a major impact on the amount and the quality of the research that could be done by nurse investigators because it's just in this day and age not very possible to do rigorous clinical research, the kind of research we want to see that will improve healthcare without substantial funds. The unfortunate bias that existed and likely still does but in a different fashion and not quite the same way in the larger research community about nurses doing research, or maybe I should say rather than bias, ignorance, just the lack of knowledge that nurses are educated at a doctoral level with substantial research skills. People think of nurses as the nurse in the hospital, and we need to do a better job of informing our colleagues and other disciplines as well as the public about all the roles of nursing. I think we definitely have been doing that, and I think the situation is quite different now. Many more people are quite aware, and many nurses now are regularly funded by other institutes as well as NINR which I think is a good thing, first of all because NINR is one of the smallest institutes, so while the money is good to have available, it's not as much as what others have. And when our research overlaps, as it often does with many other concerns, I certainly am a supporter of nurses applying to other institutes for funding should their study be central to the mission of those institutes as well as nursing.

PC: Was that part of the roadmap idea?

LA: The roadmap idea was similar, but I think beyond that. The roadmap idea was, and I think correctly, a bold statement that no one discipline has all that is needed to address the complexities of today's health problems. And so there was with the roadmap a pointed effort to get people to work across disciplines and collaboratively to the point that we might even develop additional sciences that are a blending of the work coming from different disciplines. I have always held that nursing—let me back up. When Elias Zerhouni was the NIH director and the roadmap was his initiative, he would speak about what he called an interdiscipline, and he would use neuroscience as a good example of an interdiscipline because it emerged from bringing together several other disciplines and now is recognized as a discipline unto itself. I have always believed, and in fact have presented in some forums and addresses that I've been invited to give, that nursing is in fact an interdiscipline, that our science is a rich blending of many social and biological sciences. It's what we do, and we don't even think about it. We don't recognize how ahead of the curve we've always been, and I personally think that has been to our detriment, that we have always been charged—when we first started in this whole research enterprise, when there were very few doctoral programs in nursing, most of us got our doctorates in other disciplines, so we became experts in those disciplines. And then we came back to nursing, and our charge was to figure out how to take that knowledge and apply it to nursing and make it relevant for nursing, meaning nursing practice, nursing care, the health conditions and concerns of the patients we treat. And what else is an interdiscipline? For example, I got my degree in sociology, but with my nursing background, I also have some of the physiology that can be brought to bear when one considers the problems we have to study. I always thought it gave me a leg up when I studied medical sociology over classmates who were pure sociologists who came out of undergraduate programs in sociology. So to them, thinking about when in medical sociology they start studying health services, delivery systems and such, it became very clear that because I was a nurse and had a different life experience and professional experience, I heard, read, and could relate to that content very differently than my colleagues in sociology.

PC: Ada Sue Hinshaw would say the same thing.

LA: I'm sure she would.

PC: Also coming out of sociology.

LA: Right. I know. We're good friends.

PC: You said that there was a bias or an ignorance but that had changed. Could you expand on that for me a bit . . . from the medical community versus the nursing?

LA: Actually I don't want to be too optimistic about this unfortunately. I wish I could. But I do want to at least acknowledge that things aren't the same as they were when I began in this enterprise. When I began, I can tell you two stories.

PC: This is the early eighties?

LA: Very early eighties or even late seventies. I had a professor in a decision theories graduate-level course, because I was interested in people's decision-making around engaging in healthy behaviors, and he wrote on a take-home mid-term—that, by the way, I got the highest grade in the class, which I didn't know, he told me that afterwards—but he wrote this comment that I wrote like a hundred other HEW bureaucrats—at that time HHS was HEW—and that I could do more for my nursing career by cleaning up my writing than getting a Ph.D. I of course challenged him on that premise, but that to me represented a lack of knowledge or understanding about why nurses would be studying at a doctoral level or need a doctoral degree. If you talked about doing nursing research in those days, people would say, "Nursing research? What's that?"

PC: Sometimes they still do.

LA: Unfortunately, yes. I was just going to say that. But that was very universal. Today, as you say, people still don't get it, but there are fewer of them, there's a little more recognition, and at least as more—unfortunately, some of it has been like on a case-by-case basis. But as enough of us have been out there, that there now is an increasing number of nurses with Ph.D.'s, and I've always pushed for us to be more visible outside of nursing, to get more involved with our colleagues outside of nursing, and to get beyond, oh you're the exception, to oh yes, nursing has something to contribute to this. And so my more recent example comes from the roadmap. When I was at NIH and working on some of the roadmap committees, one of the physicians from another institute who was heading up one of the efforts said to me one day, and I talked to him about this after because I've used it in talks and that's why I remember it, because I asked his permission if I could and he said sure. He said, "Well, you know, I always knew we had the nursing institute, but until I met you, I never really understood what nursing research was all about." So it's breaking the cracks. Now this same physician was leading a group of the PIs and the NIH staff, but mostly the PIs of the first round of roadmap clinic research K12 programs, and I was at that meeting. It was an all-day meeting, and it began with people going around the room talking about their experience setting up the program, and one investigator said, "Well, we went over to our nursing school and we discovered that they've been doing clinical research all along." And then somebody else said, "We, too, found that the nurses were doing some clinical research." So at the end of the day, the original physician who said he hadn't known about nursing research, in summing up the day to everybody, said, "And another thing we all learned today that I think no one really knew before, except Lauren, is that nurses get it. Nurses do clinical research." So it makes me a little more optimistic. It's like I don't want to groan. I have to warn my nursing colleagues, when you have experiences like that, you don't groan why don't they already know that. Why they don't already know that is our fault. Not theirs. Nobody's sitting around saying, "Gee, I wonder what nurses do." It's really our responsibility to be noisy about it, to be out there, and I think we have a social responsibility because we have a lot to offer, and to not do that is I think withholding.

PC: That's been a theme that runs through the history of nursing at NIH and before Congress since 1986.

LA: Oh yes. There are issues.

PC: That would lead me to the question I'm going to ask in reverse order, but since we're on this, what do you think have been the failures of the NINR or NCNR over the years, let's say the past twenty-five years?

LA: The failures.

PC: Or to put it another way, where could they have done better.

LA: I think in terms of visibility, and I think that . . . I believe that the nursing institute has had, how do I say this, a lot of good people working there, but sometimes we had people who were too junior. And I think by having had less experienced staff in the institute, they weren't able to be as savvy or to carry their weight and have the same credentials as some of their colleagues from other institutes, through no fault of their own. That's one issue. I don't think it's the whole story.

PC: When you're talking about staff, are you talking about the office staffing or the intramural staff?

LA: The intramural program had been slow in getting up and running. I think it's a little more robust now. But I was thinking of the program officers and such. And like I say, delightful people and good people and have some strengths and it's not uniform, but I think a large number of them . . . our program officers in my—and believe me I don't know the whole list and I know they change and I actually am not even sure I know all of them now who are currently the program officers. [Inaudible] just yesterday told me that he has a new program officer that he really liked and was really helpful, and he's a statistician, he's not a nurse, but he's putting in a grant that he's hoping NINR will fund. But I don't think that they came to NINR to those positions with a personal history of having been NIH funded and having had a strong research record. That's just been my impression. Obviously I haven't studied it. I don't know for sure, but that's been my impression, and I think that may have hurt us.

PC: Is this because there's not any reward for these people to come for two or three years and be away from the university base?

LA: I think it's hard. Yes, I think it's hard. And I think it's difficult—it's always sometimes a little harder to get women to move than men, to move their families, and so there's always that. And I think that in the research domain, we're a young discipline. I think we've done a tremendous job in a short period of time if you compare us with our colleagues in other fields in that sense. But being a young discipline, one, we didn't have a very large pool to select from, two, people were less—those who were launching successful research careers understandably don't want to interrupt that, and so that has an impact, but I think that would help. And I think a general tendency among nurses—I hate making these generalizations—but there is a tendency among nurses not to be particularly assertive in interdisciplinary groups, and that's unfortunate. I happen to be a noisier person. For example, again drawing from a roadmap example, the first meeting of one of the groups that I went to was about, again it was in the clinical research roadmap arm, and I think it was about the K12 program. I'm pretty sure it was about the one that was—it was going to be training the scholars to getting more people to become clinical researchers, and they were talking about the trainees and the mentors and the what-have-yous. So we were on the discussion of mentors and such, and I'm sitting there listening to their discussion, and it made infinite sense to me that there were now, today, a few years ago but at that time plenty of nurse investigators at universities who would be excellent mentors for physicians and others who were learning to become clinical researchers. And so I spoke up. It may have been my first meeting, but I'm there, I'm contributing, so I said, "Well nurses, too" as they were talking about mentors. And the response I got was a pat on the head and, "Yeah, well, we will think about training nurses down the road, but we're really interested in getting physicians trained." To which I responded and said, "Oh, I'm sorry. I wasn't very clear. I was talking about the nurses being the mentors." [Laughs] And it went over like a lead balloon at the time, just some silence, but I think it was when the group was still struggling with their charge to be interdisciplinary, or multidisciplinary I should say. I did a little behind-the-scenes conversations about that and things turned around some, including that when we were reviewing applicants and the . . . I don't know if they still do that, but in the first round the awardees had to submit the mentee and mentor teams to NIH for approval. So when I looked them over and I saw somebody doing work in an area that I knew a nurse investigator was doing work, I made sure to send back information to that PI with the contact information and everything saying that person ought to contact, for example, Dr. Carolyn Sampselle at the University of Michigan. She does a lot of work on urinary incontinence, and she would be a great resource. And somebody else about whatever the topic was, if I knew a nurse investigator doing funded work in that area, I would refer them and hope that my colleagues did not turn anybody down when they got a call, which I don't think they did or would. And people did, and I have people that still—well, here. I've been doing it here as well. I teach a grant-writing class for the medical center here and there is a physician—I get a lot of people in the class, a lot of physicians as well, and one physician, a urologist who was in the class many years ago, was interested in incontinence and I referred him to Carolyn Sampselle, and they continue to have contact over the years and collaboration.

PC: We talked about some of the, if not failures the lack of success. What do you think has been the greatest success of NINR over the last quarter century . . . aside from the money?

LA: It's the flipside of the same thing. It is to whatever extent raising nursing's visibility in the research community. I'd like to see more of that, but if it didn't exist, that certainly wouldn't be there. And I do think the research that has been funded, pure and simple to me, the success of the institute is the knowledge that we have gained that has led I assume to significant improvements in practice and in the health of people as a result of this research. It's a quiet success.

PC: I guess looking ahead, since nurses don't have a particular disease they do bench science on, does the trend toward for want of a better word wellness or prevention, if I read the health plans that are coming out of Washington now, that emphasis might give a greater role to nursing in the future? I should say nurse researchers.

LA: It certainly should, and if it doesn't, it certainly is largely our responsibility and our fault. I think the American Academy of Nursing is doing some tremendous work in that area to enhance the visibility of nursing in the healthcare debates that are going on and in health policy decision-making. And what the American Academy of Nursing is trying to do is to showcase what nursing is contributing to healthcare in this country through direct service but through the evidence of the benefits of that service, and that evidence comes from research. When I was at NIH for those two years, we did a brief . . . I'm not sure what to call it, inquiry of the community about a potential name change for the institute, and I don't know what happened to that other than the direction things were going, never any unanimity, but the direction things were going was a recognition that what we do is biobehavioral science, and psychologists were very upset, and I don't know what happened that we abandoned that because of that. When nursing first got an institute at NIH, the first thing that crossed my mind was that we were going to get creamed because psychology was going to discover us and they were going to put in the more competitive proposals because they had a longer history of this research, they were more assertive, they were going to send in health psychology. When the whole field of health psychology came out, I looked at it and I said, "And what is that different than nursing?" To me, I don't quite see much difference. It's really all a lot of overlap. Lo and behold that didn't happen because we were so far under the radar that they didn't even discover us. They didn't even realize that was a pot of money they could have been applying for. I don't know what caused that. I was always on the fence because I wanted to see of course my nursing colleagues having a chance at this, but I think we are now competitive enough, we can get funded from any institute to which our research is addressing their mission and we should, and I think we need to lay claim to an area of science that we make a distinct contribution to.

PC: What was the proposed name change?

LA: There were lots of different iterations. I don't recall the exact language. It was a lot of words missing, and there was alternatives and such.

PC: National institute for biobehavioral research?

LA: Nursing was in there as well. For nursing and biobehavioral research or something like that. It's sort of like dental has. It used to be the National Institute of Dental Research. Now they're the National Institute of Dental and Craniofacial Research, and nobody argued because that's what dentists do. They do research on the face and the cranium. You know, the jaw and the . . . bone research. Dentists do bone research. Do the orthopedists object? No. They work collaboratively. The renal, kidney people because of all the bone metabolism involves the kidney and stuff. No. They're all involved. Why we get stymied and stopped because psychology thinks it has a claim to the concept of biobehavioral?

PC: Define biobehavioral for me.

LA: An integration of biological and behavioral issues and concerns. When we look at health problems of people, we weigh both. That's what nursing does. Symptom management is another. When I explain what nursing research is, I often say—because people understand medical research and I always get a kick out of that because who does medical research? Well yes, physicians do medical research but most of it comes from the basic sciences, not from the M.D.'s. There are exceptions. My partner in crime here that I work with extremely closely is an M.D., and he does research and he doesn't have a Ph.D. Some M.D.'s have a Ph.D. as well and have gotten that. Some have gotten it through fellowships and such and they learn it, but by and large their science is coming out of basic sciences, not applied discipline. We're an applied discipline. No different.

But everybody understands medical research, and medical research, if everybody would think about it and put it in a small capsule, would say its goal is to find the cause and the cure of diseases. That's very clear. So my response is to say all right, we all know about what medical research is doing. Medical research is looking for the causes of diseases and how we can cure them, and that's fabulous and I laud them and I want them to find all the cures in the world, truly. But until we have a cure, until we can eradicate various diseases, people get them, people have health problems, and they have to figure out how to live the healthiest and the highest quality life in face of those health problems. They're going to have symptoms like pain, like fatigue that they're going to have to learn how to cope with in a way to make their life at the highest quality possible, and that's where nursing comes in. Nursing focuses on the management of health conditions, of symptoms, and focuses on issues about how do we prevent the disease in the first place, what kinds of healthy behavior should we engage in and understanding that.

When I explain this to a colleague or a layperson, I don't then go in and say of course others are interested in this, too, which they are, but that's the heart of nursing. I don't think we have a unique and exclusive hold on that and we need to recognize that. I of course was also one of those nurses in the early days of nursing theories that did not believe that we had to have a unique nursing theory, that we needed to look at all theoretical perspectives and find the one that best fit the situation or tweak it and apply it in the situation, that there didn't have to be anything inherently nursing about it. And frankly I have physician colleagues who are interested in prevention, in promoting healthy behaviors, in helping manage symptoms and that's great.

PC: Let me just pursue something here. Looking ahead over the next ten years perhaps, what would you say would be the trends in nursing research?

LA: I think I'm not as close to this part of nursing science right now, but I believe there is a larger integration of more basic science work as foundational.

PC: As foundational to the type of research nurses do?

LA: To the problems that nursing faces and therefore nursing research needs. That maybe we started out looking at, let's take pain and just figuring out how to measure it, what are alternatives, non-pharmacologic interventions that we can do to help alleviate pain. And I think that now there's a lot more bench research going on trying to understand better the mechanisms underlying pain that might give us additional insight into how we can intervene to alleviate pain. So that's one area.

Another area that I would love to see a lot more work done is in the area of the delivery of healthcare and healthcare services, and what's going on today in the political arena, it is astounding to me that there isn't widespread recognition and acceptance of the role that nurse practitioners can play. And I think that what will continue to help that is increasingly more and more research. Now I just read somewhere, it was either a *JAMA* article or an *Annals of Internal Medicine*. I think it may have been *Annals of Internal Medicine*. I wasn't reading the actual article. What I read was a reference to this article is the thing. That's why I'm not remembering what was the site they were saying. But it had to do with the concern about the healthcare at the minute clinics. It was like a sidebar in something. I'm totally blanking on what it was and what context I saw this. It just said in a recent and I think it was *Annals of Internal Medicine* article, and it did not ever mention the word nurse, and I assume—now I know there's physician assistants that staff those as well, but clearly there's nurse practitioners. And it was some large study that was looking at the quality of care, and it basically found either no difference or that the care was even better.

PC: Yes. I saw an article in the *New York Times* on that probably late July or early August, sometime in the last two months that was highlighting a clinic, and the bottom line was that the healthcare delivery was pretty even and a lot less expensive, I believe was the point it was making.

LA: Yes. And I think this one was referring to something that was more than one clinic, but I don't know for sure.

PC: Often a reporter will just take the local one and run the same number on it.

LA: That kind of information needs to be out there because politically we know the AMA is not happy about it and certainly not the pediatric subspecialty. I don't know what their group is because I've had a student who was . . . I don't remember whether he was a pharmacist or a pediatrician in the grant writing class who was interested in these and wanting to study something about that because there was a lot of concern. They're always concerned because it'll hit their pocket.

PC: Everybody seems concerned by that. In looking at this, what role is nursing going to play in developing healthcare policy in the next ten years, or can it play?

LA: It certainly can, it certainly should, and sadly I'm a little jaded, but I don't think it's going to play as big a role as it should.

PC: Why?

LA: Because it's always an uphill battle and we have to be really noisy and we don't have the lobbying power that the AMA has or that the hospital association has.

PC: Even though they used to say that there were, I don't know, 400 nurses in every congressional district or whatever the ANA used to say about that?

LA: Right. But I've held for many years that our size has actually worked against us and not for us. We always try to tout that we're the largest healthcare profession and we probably are and that quote there's power in numbers, but the problem is those numbers are incredibly divisive and heterogeneous and spend a whole lot of time fighting among ourselves. I don't recall. Are you a nurse as well?

PC: No. I'm a historian.

LA: That's right. I knew the history background but I didn't..... We still don't have a baccalaureate level entry into practice to nursing. This is unbelievable to me. Absolutely unbelievable. Maybe it shouldn't be unbelievable given what I know about the infighting that goes on and the shortsightedness of self-interests, etc. This has been going on—I think the ANA issued the first statement in 1965 to call for a bachelor's degree as the entry into practice. At that time we had hospital schools, community colleges, and universities. So when you don't have—actually back in 1989 I published a paper in *Nursing Outlook* on looking at the historical . . . I'm trying to think what I titled that . . .

A challenge for nursing: Reviewing a historic competition. I used social exchange theory to look at the history of medicine and the history of nursing over control over healthcare. It was meant to be provocative. It didn't get a whole lot of response, but it seems that the issues are still alive and it's always puzzled me, but it really tried to look and say, taking social exchange theory and saying medicine got it right. They had the Flexner report and they shut down every medical school that wasn't like Johns Hopkins, and you could only become a doctor and licensed to be a doctor if you graduated from one of those schools. Nursing had the Goldmark report. Didn't happen. The Goldmark report predated the ANA statement about saying nursing should be educated at the university level.

PC: It sounds like historians. They're the last to change.

LA: And all sorts of things. And what does social exchange theory say? It says you've got power when you're small in numbers and you've got a monopoly over what people want. We, in our diversity, spend all our time fighting each other. I'm just as good as you and I don't have a college degree. It's not at a personal level. It's at a social level, a discipline level, a social institution level, and think about the greater good for people. The other thing that I really faulted nursing about—and I think nursing still is not doing as good a job as we could, we're doing better, I'm getting old so I'm getting impatient—is that we never recognized that we kept trying to talk to doctors. We kept trying to say hey, we just want to collaborate, we're complementary, we don't want to compete. Well the truth was, whether we wanted to compete or not, we were competitive and they recognized it and we didn't. The partner that we should've been talking to, and still need to be talking to, is the public. They're our partner. They're our exchange partner. They're the ones that we need to talk to to say this is what you deserve. This is the kind of healthcare you should have. And then let the public choose.

In fact, I work out, I have a trainer, and just last night during my workout he was giving me his latest health report. He has a number of health conditions. He looks as healthy as can be. He doesn't have an ounce of fat on him, he's all muscle and everything, but he has got a number of health conditions. So he was giving me his latest report and everything and all of his different doctors and everything, and I was saying, "Now is that one your primary care?" He says, "No, no. I have another one that's my primary. I wish there was somebody who would just take everything together." I said, "Yes. That's why I like nurse practitioners."

PC: That may be the future.

LA: It ought to be. I think our healthcare would be greatly improved.

PC: Is there anything I've omitted or left out? What I'm trying to do here is put together sort of our last chapter of the book.

LA: I think you're in a better position to identify that than I am in terms of what your needs are. I hope I've been helpful in that regard.

PC: Very, very. And I want to thank you very much. I'm glad we finally had the chance to talk. I appreciate it.

LA: You're very welcome. I'm happy to.

PC: I'll take the opening if I need to to call you back sometime if I need to fill in a blank.

LA: Absolutely. I just want to see us charge forward. We have so much to offer, it's a crime if we don't.

PC: I may use that quote.

LA: Okay.

PC: Thanks very much. I appreciate it.

LA: You're very welcome.

PC: Bye.

LA: Bye.

[End of interview]